

AUTHORIZATION FOR RELEASE OF INFORMATION

PALMETTO CARDIOLOGY OF YORK COUNTY

NAME OF PATIENT _____ DOB: _____

Chart # _____

PALMETTO CARDIOLOGY OF YORK COUNTY is authorized to release protected health information about the above named patient to the entities named below at the request of the patient or patient’s representative.

_____ Leave health information on voice mail

_____ Give information to spouse

_____ Give information to the following person(s).

Name	Relationship
_____	_____
_____	_____

Description of information to be released:

___ Financial Information ___ Appt Reminder ___ Test Result(s) ___ Other Information

Rights of the Patient

I understand that I have the right to revoke this authorization at any time as well as to inspect or copy the protected information to be disclosed as described in this document by sending a written notification to Palmetto Cardiology of York County. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse signing of this authorization and that my treatment will not be conditioned on signing or not signing this authorization. This authorization shall remain in force until revoked by the patient or representative signing this authorization.

Signature of Patient or Representative
Date